MIDDLESEX
HOSPITAL

February 11, 2019

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Facility Licensing and Investigations Section
Department of Public Health
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Dear Ms. Caron:

Enclosed you will find a plan of corrective action for the violations resulting from the Department of Health visit to Middlesex Hospital on January 4, 2019.

Thank you for bringing these issues to our attention, and feel free to contact me if you require any further information.

Sincerely,

P Austin

Paula Austin
Regulatory Program Manager

Enc.

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Middlesex Health
Middletown, Connecticut

CORRECTIVE ACTION PLAN

January 4, 2019

STATE FINDINGS/STATE CODE	STATE COMMENTS	FACILITY ACTIONS/ RECOMMENDATIONS	FACILITY FOLLOW-UP/RESULTS
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).	1. Based on medical record reviews, review of facility documentation and video, review of facility policies, observations and interviews, for one of three patients who required constant observations (Patient #1), the facility failed to ensure that the patient was constantly observed. The finding includes: a. Patient #1 had a history of bipolar disorder, was brought to the ED (emergency department) on 11/5/18 and had a cystoscopy for retrieval of a nail that had been self-inserted into Patient #1's urethra. Patient #1 was admitted to the ED "Red Zone" on 11/12/18 with self-injurious behavior and had undergone a cystoscopy for removal of a self-inserted nail into the urethra. A tour of the ED on 1/3/19 at 11:04 AM noted that the "Red Zone" consisted of two single, side by side patient rooms. Review of a video recording on 1/3/19 at 9:46 AM dated 11/12/18 identified S.O. (Security Officer) #1 observing the patient in the Red Zone. Patient #1 ambulated to the BR (bathroom) in the hall, closed the BR door and S.O. #1 remained in the hallway approximately 10 feet away and without the patient in constant view. An addendum ED MD note dated 11/13/18 indicated that Patient #1 had inserted plastic utensils into his/her urethra when escorted to the BR by SO #1. The	a. Observation procedure has been revised for patients in the Red-zone. Re-education of all Emergency Dept. staff and Security Dept. staff to ensure direct field of vision and close proximity to patient to be able to intervene should the need arise. Responsible party: Director Emergency Services or designee. Completion date: May 1, 2019	a. 10 occurrences per month for a period of 3 months (Feb, Mar, Apr) will be audited for patients requiring constant observation and 1:1 observation in the Red-zone for the following elements: -Orders from provider(s) when applicable. -Accurate documentation on observation flowsheet. -Visual observation of staff member completing the assigned task.

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	cystoscopy report dated 11/13/18 identified the retrieval of two plastic foreign body handles. Review of Patient #1's record and interview with Director #1 on 1/3/19 at 9:45 AM indicated that although the ED MD ordered every fifteen minute observation for Patient #1, patients in the Red Zone are on CO (constant observation). She further noted that SO #1 should have followed the patient to the BR to maintain observation of the patient however, did not do so. Review of personnel files on 1/4/19 identified that, following the incident; S.O. #1 was terminated on 11/20/18 for failure to monitor Patient #1 per facility policy. The facility policy for observation of patients identified that patients are within the direct field of vision of staff at all times when on one-to-one and constant observation.		-Type of staff: Patient Care Technician, Security Officer, or sitter.
	b. Patient #1 was a direct admitted from the 11/7/18 ED admission to the N7 BHU (behavioral health unit) on 11/14/18. Review of the psychiatric MD progress note dated 11/14/18 identified a plan to maintain one-to-one observation. Review of nursing narratives dated 11/15/18 at 12:50 PM indicated that Patient #1 remained on one-to-one with security. A video recording dated 11/15/18 was reviewed on 1/3/19 at 10:12 AM. The recording identified that on 11/15/18 at 12:54 PM, Patient #1 was being observed by SO #2, SO #2 looked out of the window for a couple of seconds and did not observe Patient	b. Observation procedure has been revised for inpatients. Re-education of all RNs and PCTs in the inpatient Behavioral Health Unit and Security Dept. staff to ensure direct field of vision and close proximity to patient to be able to intervene should the need arise. Procedure has been developed and implemented to count and reconcile utensils for all meals and snacks in the inpatient BHU. Trash containers have been removed from common areas of the inpatient BHU.	b. 10 occurrences per month for a period of 3 months (Feb, Mar, Apr) will be audited for patients requiring constant observation and 1:1 observation in the inpatient BHU for the following elements: -Orders from provider(s) when

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	#1 reach into the garbage bag near the nursing station. Patient #1 then went into his/her bed, pulled the covers over his/her body and hands were beneath the covers. Review of social service notes dated 11/15/18 at 1:44 identified that Patient #1 admitted that he/she stole a fork and inserted it into his/her urethra. Nursing narratives dated 11/15/18 at 1:56 PM identified that the patient was evaluated by the MD. Patient #1 was placed on two-to-one observation following the incident. Review of the cystoscopy report dated 11/15/18 noted that two plastic foreign bodies were retrieved from the patient's urethra. Interview with Director #1 on 1/3/19 at 10:20 AM identified that SO #2 should have had eyes on the patient at all times. Interview with SO #2 on 1/3/19 at 12:09 PM indicated that he was looking out of the window when Patient #1 reached into the garbage and that he had not had any formal training on the facility one-to-one observation policy prior to the event. The facility policy for observation of patients identified that patients are within the direct field of vision of staff at all times when on one-to-one and constant observation. Subsequent to the events, the facility submitted CAPs (corrective action plan) dated 11/16/18 and 12/6/18 to include education for security and nursing staff of the current policy for observation of patients, the development of a utensil monitoring	Responsible party: Director of Inpatient Behavioral Health Department or designee Completion date: May 1, 2019	applicable. -Accurate documentation on observation flowsheet. -Visual observation of staff member completing the assigned task. -Type of staff: Patient Care Technician, Security Officer, or sitter.

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	procedure for the BHU with the development of a stricter patient observation policy for facility governing board approval. The facility was found to be compliant with the CAP as submitted.		
	2. Based on medical record reviews, review of facility documentation and video recordings, review of facility policies, observations and interviews for two of three patients (Patient #2) who resided on the N7 BHU (behavioral health unit), the facility failed to ensure that the unit was monitored adequately to prevent an alleged sexual assault. The finding includes: a. Patient #1 had a history of Bipolar disorder and was admitted to the BHU on 11/7/18 on every fifteen minute checks. Patient #2 was 29 y/o, had a history of Schizo-affective disorder, sexual trauma, was developmentally delayed with mild to moderate intellectual disability and was admitted to the BHU on 11/8/18 for suicidal ideation. Patient #2 was placed on every fifteen minute checks on 11/8/18 at 2:45 PM per the physician order. Review of the monitoring sheets for Patient #1 dated 11/8/18 at 4:45 PM indicated that he/she was talking to staff/others and was eating at 5:00 PM. Patient #1 was discharged to home on 11/9/18. Review of monitoring sheets dated 11/8/18 identified that Patient #2 was talking to staff/others at 4:45 PM and was eating at 5:00 PM. Review of MD notes for Patient #2 dated 11/10/18 indicated that Patient #2 alleged that Patient #1 came into his/her room the night that he/she was admitted (11/8/18)	2. Procedural changes for the observation of patients and monitoring of the common area on the inpatient Behavioral Health Unit has been implemented. This change includes an assigned staff member in the inpatient BHU common area at all times while completing Q15 minute observational checks. This assignment will be designated on daily staffing sheet. Responsible party: Inpatient Behavioral Health Director or designee Completion date: May 1, 2019	2. 10 occurrences per month for a period of 3 months (Feb, Mar, Apr) will be audited for common area observation in the inpatient BHU for the following elements: -Assessment of Daily assignment sheet with a designated staff member in observation role. -Accurate documentation on observation flowsheets. -Visual observation of staff member completing the assigned task. -Type of staff: Patient Care Technician, Security Officer, or sitter.

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	and that he/she was sexually assaulted by Patient #1. Patient #2 was subsequently tested for sexually transmitted diseases, a rape test kit was performed and results were negative. The video recording dated 11/8/18 from 4:38 PM to 4:44 PM identified Patient #1 and Patient #2 in the common area at the table drawing pictures and touching each other's peri area and/or touching the other's breast. Further review identified that Patient #2 went into his/her bedroom and Patient #1 entered Patient #2's bedroom and closed the door. Patient #1 was observed on the video to leave Patient #2's room at 4:55 PM and both patients were observed sitting next to each other in the common room eating dinner and interacting at 5:01 PM. Interview with Manager #1 on 1/3/19 at 11:35 AM indicated that PCT #2 (patient care tech) was in charge of the 15 minute checks of the BHU patients on 11/8/18 and assisted with a patient admission between checks and during the time of the incident. Further interview identified that the person assigned to 15 minute checks was responsible for the safety of the unit. Although the facility policy for patient observation did not include monitoring of the common area, the facility patient rights policy indicated that the patient had the right to safe care at all times. Subsequent to the event, the facility submitted a CAP (corrective action plan) to include incorporation of the staff assigned to the		

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	common area onto the nursing assignment sheets, education of staff on "full unit" observation and changes to the patient observation policy. The facility was found to be compliant with the CAP as submitted.		

"The Hospital's development and implementation of this corrective action plan does not constitute an admission of any fact or violation of law, or a statement that any Hospital policy was not adequate or properly implemented. This corrective action plan has been prepared and will be implemented to comply with regulatory requirements and to further the Hospital's objective of continually improving patient care."